ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
MEDICARE/MEDICAID COORDINATED BENCHMARK BENEFIT PACKAGE FOR ELDERS AND/OR INDIVIDUALS WHO ARE DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID

1937(a), 1937(b) _X_ / The State elects to provide alternative benefits under Section 1937 of the Social Security Act.

A. Populations

The State will provide the benefit package to the following populations:

a. ___/ Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006, will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals exempted from such a requirement.

List the population(s) subject to mandatory alternative coverage:

NONE

b. _X_ / Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

List the populations/individuals who will be offered opt-in alternative coverage:

Recipients of Supplemental Security Income
SSI-Related Individuals
Recipients of Mandatory State Supplements
Recipients of State Supplementary Payments
Recipients of Hospice Care
Recipients of Long-Term Care

All of the above populations/individuals must be enrolled in Medicare Part B and Medicare Part D. Individuals under age 21 and with End Stage Renal Disease (ESRD) are excluded.

For the opt-in populations/individuals, describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

See Section 2.D of Attachment

For the opt-in populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.

Covered services including services provided under a Medicare Advantage Plan, Integrated Medicaid Services and services provided by Medicaid providers are identified in Section 3 of Attachment.

c. _X_ / Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

List any geographic variations:

See Section 1.C of Attachment

Please provide a chart, listing eligible populations (groups) by mandatory enrollment, opt-in enrollment, geography limitations, or any other requirements or limitations.

B. Description of the Benefits

_X_ / The State will provide the following alternative benefit packages (check all that apply). *Medicare/Medicaid Coordinated Plan*

1937(b)

1. _X_ / Benchmark Benefits

a. ___ / **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider

option services benefit plan, described in and offered under section 8903(1) of Title 5, United States Code.

b. ___/ **State Employee Coverage** – A health benefits coverage plan that is offered and generally available to State employees within the State involved. Attach a copy of the State's employee benefits plan package.

c. ___/ **Coverage Offered Through a Health Maintenance Organization (HMO)** - The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved. Attach a copy of the HMO's benefit package.

d. _X_/ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State's plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

Covered services including services provided under a Medicare Advantage Plan, Integrated Medicaid Services and services provided by Medicaid providers are identified in Section 3 of Attachment.

2. ___/ Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan:_____.

a. ___/ The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) using generally accepted actuarial principles and methodologies; 3) using a standardized set of utilization and price factors; 4) using a standardized population that is representative of the population being served; 5) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into

account any differences in coverage based on the method of delivery or means of cost control or utilization used; and 6) takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage. Attach a copy of the report.

b. ___/ The State assures that if the State provides additional services under the benchmark benefit package(s) from any one of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c. ___/ The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1) ___/ **Inclusion of Basic Services** – This coverage includes benefits for items and services within the following categories of basic services: (Check all that apply).

___/ Inpatient and outpatient hospital services
___/ Physicians' surgical and medical services
___/ Laboratory and x-ray services
___/ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices
___/ Other appropriate preventive services, as designated by the Secretary

___/ Clinic services (including health center services) and other ambulatory health care services
___/ Federally qualified health care services
___/ Rural health clinic services
___/ Prescription drugs
___/ Over-the-counter medications
___/ Prenatal care and pre-pregnancy family services and supplies
___/ Inpatient Mental Health Services not to exceed 30 days in a calendar year
___/ Outpatient mental health services furnished in a State-operated facility and including community-based services
___/ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)
___/ Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements
___/ Nursing care services, including home visits for private duty nursing, not to exceed 30 days per calendar year
___/ Dental services
___/ Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year
___/ Outpatient substance abuse treatment services
___/ Case management services
___/ Care coordination services
___/ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
___/ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services
___/ Premiums for private health care insurance coverage
___/ Medical transportation
___/ Enabling services (such as transportation, translation, and outreach services)
___/ Any other health care services or items specified by the Secretary and not included under this section

(2) Additional benefits for voluntary opt-in populations:

___/ Home and community-based health care services

___/ Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan(s) including benefits and any applicable limitations.

(3) Wrap-around/Additional Services

a. ___/ The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section 1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary. Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure early and period screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).

b. ___/ the State has elected to also provide wrap-around or additional benefits.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

C. Service Delivery System

Check all that apply.

1. ___/ The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.

2. ___/ The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1915(b)(1).

3. ___ The alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirements.

4. ___/ Alternative benefits provided through premium assistance for benchmark-equivalent in employer-sponsored coverage.

5. _X_/ Alternative benefits will be provided through a combination of the methods described in item 1-4. Please specify how this will be accomplished. Payments for services covered under this benchmark plan will handled in the following manner:

- Medicare Advantage Plans will directly pay network providers based on their established fee schedule for benefits currently covered under the Advantage Plans.
- Medicaid will pay an aggregated per member per month capitated amount to Advantage Plans for integrated benefits. Medicare Advantage Plans will then pay integrated network providers based on their established fee schedule.
- Medicaid will pay Medicaid-only providers based on its established fee schedule.

D. Additional Assurances

a. _X_/ The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

b. _X_/ The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).

E. Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

_X_/ The State will continue to comply with all other provisions of the Social Security Act in the administration of the State plan under this title.

G. Implementation Date

_X_/ The State will implement this State Plan amendment on ***(October 1, 2006).***

MEDICARE/MEDICAID COORDINATED PLAN
(For Elders and/or Individuals Who are Dually Eligible for Medicare and Medicaid)
BENCHMARK BENEFIT PACKAGE

Section 1 GENERAL OVERVIEW

1.A ADMINISTRATIVE AUTHORITY

42 CFR 431.10

As a condition for receipt of Federal funds under Titles XIX and XXI of the Social Security Act, the Idaho Department of Health and Welfare submits the following Medicare/Medicaid Coordinated Benchmark Benefit Package, and hereby agrees to administer the program in accordance with the provisions of Titles XI, XIX of the Act, and all applicable Federal regulations and other official issuances of the US Department of Health and Human Services.

42 CFR 431.10 1.1
AT-79-29

The Idaho Department of Health and Welfare is the single State agency designated to administer or supervise the administration of the Medicaid program under Titles XIX and XXI of the Social Security Act. (All references to "the Department" mean the Idaho Department of Health and Welfare.)

The health benefits coverage available under the Medicare/Medicaid Coordinated Benchmark Benefit Package provides appropriate coverage for the applicable populations as determined by the Secretary of the US Department of Health and Human Services pursuant to his authority under section 1937 of the Social Security Act. (All references to "the Secretary" mean the Secretary of the US Department of Health and Human Services; all references to "the Act" mean the Social Security Act).

All other provisions of the Medicare/Medicaid Coordinated Benchmark Benefit Package are administered by the Department in accordance with statutory authority granted under Chapter 2 of Title 56, Idaho Code. The Medicare/Medicaid Coordinated Benchmark Benefit Package describe in this State Plan Amendment shall constitute the State Plan for elders and/or individuals who are dually eligible for Medicare and Medicaid.

1.B POLICY GOALS

The broad policy goal for the provision of the Medicare/Medicaid Coordinated Benchmark Benefit Package for elders and/or individuals who are dually eligible for Medicare and Medicaid is to finance and deliver cost-effective individualized care.

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Additional specific goals are:

- To emphasize preventive care and wellness;
- To improve coordination between Medicaid and Medicare coverage;
- To increase nonpublic financing options for long-term care; and
- To ensure participants' dignity and quality of life.

1.C GEOGRAPHIC CLASSIFICATION

The Medicare/Medicaid Coordinated Benchmark Benefit Package will be implemented in the geographic locations (counties) listed below. Additional counties will be added as a Medicare Advantage Plan(s) becomes available in the county.

Idaho Medicaid Geographic Area	Counties
Region 1	Benewah, Bonner, Boundary, Kootenai, and Shoshone
Region 2	Latah and Nez Perce
Region 3	Canyon, Gem, Owyhee, Payette, and Washington
Region 4	Ada and Boise
Region 5	Cassia, Minidoka, and Twin Falls
Region 6	Bannock, Caribou, Oneida, and Power
Region 7	Bonneville, Jefferson, and Madison

1.D SERVICE DELIVERY SYSTEM

Each individual that opts into the Medicare/Medicaid Coordinated Benchmark Benefit Package under the State plan shall select and enroll in a Medicare Advantage Plan.

Att 3.1 C (d)(3)

The policy goals above will be accomplished through the following methods:

- Medicare continues to be the primary payor for dual eligibles (with respect to Medicare covered benefits and, in the case of Medicare Advantage Plans, enhanced benefits included in the Medicare Advantage Plan's Medicare Advantage Plan contract with the Centers for Medicare and Medicaid Services)
- Utilization of the same provider network in coordinating benefits across Medicare (through Medicare Advantage Plans) and Medicaid.
- Integrated benefits covered by Medicaid will function like a wrap around to those Medicare benefits.

- Services identified in this benchmark plan that are not integrated with the Advantage Plan will still be available through Medicaid providers on a fee for service basis.

Section 2 COVERED POPULATIONS

2.A COVERED INDIVIDUALS

42 CFR 435.10 2.2

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available to the groups specified in this Section.

The conditions of eligibility that must be met are specified in the State plan.

Att 2.2- A

The following groups, except those under age 21 or with End Stage Renal Disease (ESRD), will be offered opt-in alternative coverage under the Medicare/Medicaid Coordinated Benchmark Benefit Package if they are eligible for Medicare.

2.A.1 Recipients of Supplemental Security Income

42 CPR 435.120 Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for aged, blind and disabled individuals receiving cash assistance as Supplemental Security Income (SSI). This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981, persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

2.A.2 SSI-Related Individuals

1902(a) (10)(A) (i)(II) and 1905 (q) of the Act Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for qualified severely impaired blind and disabled individuals under age 65, who for the month preceding the first month of eligibility under the requirements of section 1905 (q) (2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619 (a) of the Act and were eligible

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for Medicaid; or

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for qualified severely impaired blind and disabled individuals under age 65, who for the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must:

- Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
- Except for earnings, continue to meet all non-disability-related requirements for eligibility for SSI benefits;
- Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;
- Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
- Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

1634(c) of the Act	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for blind or disabled individuals who are at least 18 years of age and lose SSI eligibility because they become entitled to OASDI child benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.
42 CFR 435.122	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for individuals who are ineligible for SSI or Optional State Supplements, because of requirements that do not apply under Title XIX of the Act.
42 CFR 435.210, 1902(a)(10)(A)(ii) and 1905(a) of the Act	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for aged, blind and disabled individuals who would be eligible for SSI, or an Optional State Supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

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MEDICARE/MEDICAID COORDINATED PLAN
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BENCHMARK BENEFIT PACKAGE

42 CFR 435.211	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for individuals who would be eligible for AFDC, SSI or an Optional State Supplement as specified in 42 CFR 435.230, if they were not in a medical institution.
42 CFR 435.132	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of Title XIX medical institutions or residents of Title XIX intermediate care facilities, if, for each consecutive month after December 1973, these individuals must: • Continue to meet the December 1973 Medicaid State plan eligibility requirements; and • Remain institutionalized; and • Continue to need institutional care.
42 CFR 435.133	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for blind and disabled individuals who: • Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; • Were eligible for Medicaid in December 1973 as blind or disabled; and • For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.
42 CFR 435.134	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for individuals who would be eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. This includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan). This also includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

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42 CFR 435.135	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for Individuals who are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977, and would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.
1634 of the Act	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21. and who are deemed, for purposes of Title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.
1634(d) of the Act	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving Title II payments, and who because of the receipt of Title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive Title II payments, who would be eligible for SSI or SSP if the amount of the Title II benefit were not counted as income, and who are not entitled to Medicare Part A.
1634(e) of the Act	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) of (v) of section 1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.

2.A.3 Recipients of Mandatory State Supplements

42 CFR 435.130	Att 2.2-A	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for Individuals receiving mandatory state supplements.

2.A.4 Recipients of State Supplementary Payments

42 CFR 435.121, 435.230, 1902(a)(10)(A)(ii)(XI) of the Act	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act. The following groups of individuals who receive a State supplementary payment under an approved optional State

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supplementary payment program that meets the following conditions. The supplement must be based on need and paid in cash on a regular basis and Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement. Additionally, the supplement must be available to all individuals in each classification and available on a statewide basis and paid to one or more of the classifications of individuals listed below:

- All aged individuals.
- All blind individuals.
- All disabled individuals.
- Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CPR 435.230.

2.A.5 Recipients of Hospice Care

1902(a)(10)(A)(ii)(VII) of the Act

Att 2.2-A:

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for individuals who would be eligible for Medicaid under this State plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

2.A.6 Recipients of Long-Term Care

Suppl 1 to Att 2.6-A B.4

The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for institutionalized individuals and recipients of home and community-based services.

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42 CFR 435.231. 1902(a)(10)(A)(ii)(V) of the Act	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for aged, blind and disabled individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period.
42 CFR435.217	Att 2.2-A:	The Medicare/Medicaid Coordinated Benchmark Benefit Package is available for groups of individuals who would be eligible for Medicaid under this State plan if they were in a Nursing Facility (NF) or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group(s) covered are listed in the existing 1915(c) waivers. In the event an existing 1915(c) waiver is amended to cover any additional group(s), the Medicare/Medicaid Coordinated Benchmark Benefit Package is available to such group(s) on the effective date of the amendment. Eligibility begins on the first day of the 30-day period. In determining level of care for recipients of long-term care Services, the Department provides for an evaluation (and periodic reevaluations) of the need for institutional level of care. Requirements for Level of Care Determinations are specified pursuant to existing waiver programs authorized under section 1915(c) of the Social Security Act.

2.B GENERAL CONDITIONS OF ELIGIBLITY

	Att 2.6-A	Each individual provided the Medicare/Medicaid Coordinated Benchmark Benefit Package must meet the financial conditions of eligibility described in the State plan.
42 CFR Part 435 subpart F	Att 2.6-A	Each individual provided the Medicare/Medicaid Coordinated Benchmark Benefit Package under the State plan must meet the applicable non-financial eligibility conditions.

2.D APPLICATION PROCEDURES

42 CFR 435.10 and Subpart J	2.1 2.1(a)	The Department meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medical Assistance. The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that includes informing each eligible individual of the available benefit options. The Department will inform each individual in a covered population that enrollment

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in the Medicare/Medicaid Coordinated Benchmark Benefit Package is voluntary (i.e. participants may opt-in), and that such individuals may opt out of the Medicare/Medicaid Coordinated Benchmark Benefit Package at any time and regain immediate eligibility for Medicaid benefits under the State plan.

The Department will provide such information, in writing, to covered populations, at the following opportunities:

- Initial application for assistance;
- Notice of eligibility determination; and
- Selection of primary care case manager.

Section 3. COVERED BENEFITS

3.A GENERAL PROVISIONS

1902(a)(10)(A) and 1905(a) of the Act — Gen Prov 3.1 (a)(1

Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided in the Medicare/Medicaid Coordinated Benchmark Benefit Package as defined in 42 CFR Part 440, Subpart A.

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes benefits that are provided through a Medicare Advantage Plan, benefits that are covered through an integrated Medicaid benefit, and services provided by Medicaid providers. All individuals who are eligible for Medicare may opt in the Medicare/Medicaid Coordinated Plan.

Services not covered by the individuals chosen Medicare Advantage Plan or the Medicaid Integrated Benefit or by Medicaid providers are not covered under this plan.

3.B. HOSPITAL SERVICES

3.B.1 Inpatient Services (Medicare Advantage Plan)

Att 3.1A-PD 1

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Inpatient Hospital Services** permitted under section 1905(a)(1) of the Social Security Act.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

Once a participant exhausts the Medicare Part A 90 days lifetime limit of reserve days for inpatient hospital care, the services will be covered by Medicaid.

3.B.2 Outpatient Services (Medicare Advantage Plan)

42 CFR 440.20 — Att 3.1A-G 2a

the Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Outpatient Hospital Services** permitted under sections 1905(a)(2) of the Social Security Act.

3.B.3 Emergency Hospital Services (Medicare Advantage Plan)

42 CFR 440.170 Att 3.1A-PD 24e

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Emergency Hospital Services** are provided when necessary to prevent death or serious impairment of health and when conditions dictate use of the most accessible hospital available, even if the hospital does not currently meet the conditions for participation under Medicare or the definitions of inpatient or outpatient hospital services included elsewhere in the State plan.

3.C AMBULATORY SURGICAL CENTER SERVICES (Medicare Advantage Plan)

42CFR 440.90 Att 3.1A-G 9

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Ambulatory Surgical Center Services** in addition to services covered as Inpatient and Outpatient Hospital and Physician benefits permitted under sections 1905(a)(9) of the Social Security Act, including services provided under section 1905(a)(9).

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan

3.D PHYSICIAN SERVICES

3.D.1 Medical Services (Medicare Advantage Plan)

42CFR 440.50 Att 3.1A-G 5a

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Physician Services** permitted under in sections 1905(a)(5) of the Social Security Act. These services included office, clinic, and outpatient surgery center and hospital treatment by a physician for a medical condition, injury or illness.

3.D.2 Surgical Services (Medicare Advantage Plan)

Surgical Services. The Medicare/Medicaid Coordinated Benchmark Benefit Package includes professional services rendered by a physician, surgeon or doctor of dental surgery.

3.E OTHER PRACTITIONER SERVICES (Medicare Advantage Plan)

42CFR 440.60 Att 3.1A-G 6

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Other Practitioner Services** specified in sections 1905(a)(6) of the Social Security Act. These services

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include medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

42CFR 440.166 42CFR 440.165-66	Att 3.1A-G 23 Att 3.1A-PD 23	**Certified Pediatric or Family Nurse Practitioner Services.**
	Att 3.1A-G 6d Att 3.1A-PD 6d	**Physician Assistant Services.**
	Att 3.1A-G 6c Att 3.1A-PD 6c	**Chiropractor Services.**
	Att 3.1A-G 6a Att 3.1A-PD 6a	**Podiatrist Services.**
	Att 3.1A-G 6b Att 3.1A-PD 6b	**Optometrist Services.**
	Att 3.1A-G 17 Gen Prov 3.1 (a)(1)(ii)	**Certified Nurse-Midwife Services.**

3.F PRIMARY CARE CASE MANAGEMENT (Integrated Benefit)

The Medicare/Medicaid Coordinated Benefit Package includes Primary Care Case Management Services permitted under section 1905(a)(25) of the Social Security Act. These services are provided by a primary care case manager consistent with sections 1932(a) and 1937 of the Social Security Act.

The Medicare Advantage Plan Primary Care Case Management providers can be the same network of PCCM providers under the Basic and Enhanced Plan Benefits Packages. The Medicare Advantage PCCM will be responsible for coordinating Medicare Advantage benefits, Integrated benefits and Medicaid-only provider services.

Primary Care Case Management is the process in which the physician, who is responsible for the primary care of a recipient, initiates, refers and/or coordinates the other Medicaid covered health care services needed by the recipient.

3.G PREVENTION SERVICES AND HEALTH ASSISTANCE BENEFIT SERVICES

The Medicare/Medicaid Coordinated Benchmark Benefit

Services billed under TCM must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TCM services require a referral from the PCCM.

Target Populations. TCM services, as defined in this section, will be provided for the following target group(s) as permitted in accordance with section 1915(g) of the Act.

- Individuals with a developmental disability
- Individuals who receive personal care services
- Individuals with severe and persistent mental illness

Choice of TCM Providers. Eligible recipients must be given the option to select his or her TCM provider from a list of qualified providers.

Targeted Case Management Functions (for all target populations). TCM Services are limited to the following functions:

- Assessment for the need for TCM services - Evaluation of the recipient's ability to gain access to needed services, coordinate or maintain those services and identify the services and supports the recipient needs to maintain his highest level of independence in the community.
- Development of a TCM Service Plan - Plan on how provider will meet the case management needs of the recipient.
- Linking the recipient to needed services - Finding, arranging and assisting the recipient to maintain services, supports and community resources identified in the service plan.
- Monitoring and coordination of services - Assisting the recipient and his family or guardian to coordinate and retain services, and assure consistency and non-duplication between services. Also includes assuring that services are satisfactory to the recipient and making adjustments in the TCM service plan when needed.
- Crisis assistance - Linking to, advocating for, and coordinating emergency community resources in order to resolve a crisis such as hospitalization or incarceration.

Case Manager Provider Qualifications.

- Education - Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college; or be a licensed professional nurse (RN)
- Experience - Must have at least twelve (12) months experience working with the target population they will be serving or be supervised by a case manager who meets the supervisor qualifications.

Package includes **Prevention Services** permitted under sections 1905(a)(3), 1905(a)(5), 1905(a)(6), 1905(a)(9), 1905(a)(13), 1905(a)(28) of the Social Security Act.

3.G.1 Adult Physicals (Medicare Advantage Plan)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes an annual preventive health visit. Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.G.2 Screening services (Medicare Advantage Plan)

Att 3.1A-PD13b

Mammography Services. The Medicare/Medicaid Coordinated Benchmark Benefit Package includes screening Mammographies. Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.G.3 Prevention and Health Assistance (PHA) Benefits (Integrated Benefit)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes health/wellness education and intervention services as defined by the individual Medicare Advantage Plan.

Enhanced PHA benefits made available under the Medicare/Medicaid Coordinated Benchmark Benefit Package will be targeted to individuals who:

- Use tobacco, or
- Are obese.
- Are diabetic

3.H LABORATORY AND RADIOLOGICAL SERVICES (Medicare Advantage Plan)

42 CFR 440.30 Att 3.1A-G 3

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Laboratory and Radiological Services** permitted under sections 1905(a)(3) of the Social Security Act. These services include imaging and laboratory services for diagnostic and therapeutic purposes due to accident, illness or medical condition, as well as X-ray, radium or radioactive isotope therapy.

3.I PRESCRIBED DRUGS

3.I PRESCRIBED DRUGS UNDER PART D (Medicare Advantage Plan)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Prescribed Drugs** permitted under sections

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1905(a)(12) of the Social Security Act. These services include drugs covered under the individual Medicare Advantage Plan subject to the Medicare Advantage Plan limitations and Medicare Part D excluded Drugs.

3.2 MEDICARE EXCLUDED DRUGS (Integrated Benefit)

Under this plan, the Medicare Advantage Plan becomes responsible for the Medicare excluded drugs and is expected to provide this coverage through the same network of providers as the Medicare Part D drugs.

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes the following Medicare excluded or otherwise restricted drugs or classes of drugs.

Lipase inhibitors subject to Prior Authorization.

Prescription Cough & Cold symptomatic relief.

Therapeutic Vitamins which may include:

- Injectable Vitamin B12;
- Vitamin K and analogues;
- Legend folic acid;
- Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and
- Legend Vitamin D and analogues.

Nonlegend Products which may include:

- Insulin;
- Disposable insulin syringes and needles;
- Oral iron salts;
- Permethrin; and
- OTC products as authorized by applicable Department rules.

Barbiturates.

Benezodiazepines.

Att 3.1A-PD 12A3

Additional Covered Drug Products. Additional drug products will be covered as follows:

Att 3.1A-PD 12A3(a)
- Therapeutic Vitamins;

Att 3.1A-PD 12A3(a)(i)
- Injectable Vitamin B12 (cyanocobalamin and analogues);

Att 3.1A-PD 12A3(a)(ii)
- Vitamin K and analogues;

Att 3.1A-PD 12A3(a)(iii)
- Pediatric vitamin-fluoride preparations;

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Att 3.1A-PD 12A3(a)(iv)
- Legend prenatal vitamins for pregnant or lactating women;

Att 3.1A-PD 12A3(a)(v)
- Legend folic acid;

Att 3.1A-PD 12A3(a)(vi)
- Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and

Att 3.1A-PD 12A3(a)(vii)
- Legend Vitamin D and analogues.

Att 3.1A-PD 12A3(b)
Prescriptions for non-legend products will be covered as follows:

Att 3.1A-PD 12A3(b)(i)
- Insulin;

Att 3.1A-PD 12A3(b)(ii)
- Disposable insulin syringes and needles;

Att 3.1A-PD 12A3(b)(iii)
- Oral iron salts; and

Att 3.1A-PD 12A3(b)(iv)
- Permethrin.

- Nicotine cessation products, diet supplements and weight loss products are excluded unless provided as PHA benefits.

3.J FAMILY PLANNING SERVICES (Medicare Advantage Plan)

42 CFR 441.20, AT-78-90 Gen Prov 3.1(e)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Family Planning Services** permitted under sections 1905(a)(4)(C) of the Social Security Act.

3.K MENTAL HEALTH SERVICES

3.K.1 Inpatient Psychiatric Services (Medicare Advantage Plan)

42 CFR 441.101, 42 CFR 431.620(c) and (d) AT-79-29 Gen Prov 3.3

In addition to Psychiatric Services covered under Inpatient Hospital Services, the Medicare/Medicaid Coordinated Benchmark Benefit Package includes **inpatient psychiatric services for individuals in Institutions for Mental Diseases** permitted under section 1905(a)(14) of the Social Security Act.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

Once a participant exhausts the Medicare Part A 190 days lifetime limit for inpatient mental health care in a psychiatric hospital, the services will be covered by Medicaid.

3.K.2 Outpatient Mental Health Services (Medicare Advantage Plan)

42CFR 440.90 Att 3.1A-G 9

In addition to Mental Health Services covered under Outpatient Hospital Services, the Medicare/Medicaid Coordinated

Benchmark Benefit Package includes **Clinic Services** permitted under sections 1905(a)(9), 1905(a)(13) of the Social Security Act.

Att 3.1A-PD 9
Att 3.1A-PD 9a

Clinic services are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.K.3 Psychosocial Rehabilitative Services (PSR) (Medicaid Providers)

Att 3.1A-PD
13d(2)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Psychosocial Rehabilitation (PSR) services** provided to reduce to a minimum a participant's mental disability and restore the participant to the highest possible functional level within the community. These services are outlined in applicable Department rules.

Att 3.1A-PD
13d(2)(a)

Limitations. The following service limitations apply to The Medicare/Medicaid Coordinated Benchmark Benefit Package covered under the State Plan, unless otherwise authorized by the Department are:

Att 3.1A-PD
13d(2)(a)(i)

- A combination of any evaluation or diagnostic services is limited to a maximum of six (6) hours in a calendar year.

Att 3.1A-PD
13d(2)(a)(ii)

- Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours in a calendar year.

Att 3.1A-PD
13d(2)(a)(iii)

- Community crisis support services are limited to a maximum of five (5) consecutive days and must receive prior authorization from the Division of Family and Community Services.

Att 3.1A-PD
13d(2)(a)(iv)

- Individual and group psychosocial rehabilitation services are limited to twenty hours (20) per week and must receive prior authorization from the Division of Family and Community Services. Services in excess of twenty (20) hours require additional review and prior authorization by the Department.

Excluded services. The following services are excluded from the Enhanced Benchmark Benefit Package covered under the State plan.

Treatment services rendered to recipients residing in inpatient

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medical facilities including nursing facilities or hospitals, is excluded.

Recreational therapy, which includes activities which are primarily social or recreational in nature, is excluded.

Job-specific interventions, job training and job placement services which includes helping the recipient develop a resume, applying for a job, and job coaching, is excluded.

Staff performance of household tasks and chores, is excluded.

Client staffing within the same PSR agency, is excluded.

Services for the treatment of other individuals, such as family members, is excluded.

Any other services not listed in applicable Department rules, are excluded.

3.L HOME HEALTH CARE (Medicare Advantage Plan)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Home Health Care Services** permitted under sections 1905(a)(7), 1905(a)(8), of the Social Security Act.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan

3.M THERAPY SERVICES (Medicare Advantage Plan)

Att 3.1A-G 7d

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Therapy Services** permitted under sections 1905(a)(11), 1905(a)(13) of the Social Security Act. These services include physical therapy, occupational therapy, or speech pathology and Audiology services.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan

3.N SPEECH, HEARING AND LANGUAGE SERVICES (Medicare Advantage Plan)

Att 3.1A-G 11c

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Speech, Hearing and Language Services** permitted under section 1905(a)(6) of the Social Security Act. Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan

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3.O MEDICAL EQUIPMENT, SUPPLIES AND DEVICES

3.O.1 Medical Equipment and Supplies (Medicare Advantage Plan)

Att 3.1A-G 7c

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Medical Equipment and Supplies** permitted under section 1905(a)(28) of the Social Security Act. These services include durable medical equipment and other medically-related or remedial devices. These also include medical supplies, equipment, and appliances suitable for use in the home.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.O.2 Specialized Medical Equipment and Supplies (Medicaid Providers)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Specialized Medical Equipment and Supplies** permitted under section 1915(c)(4)(B) of the Social Security Act.

Specialized Medical Equipment and Supplies are covered for participants receiving home and community-based services pursuant to a waiver program authorized under section 1915(c) of the Social Security Act.

3.O.3 Prosthetic Devices (Medicare Advantage Plan)

42CFR 440.120 Att 3.1A-G 12

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Prosthetic Devices** permitted under sections 1905(a)(6) and 1905(a)(12) of the Social Security Act. These services include prosthetic and orthotic devices and related services prescribed by a physician and fitted by an individual who is certified or registered by the American Board for Certification in orthotics and/or prosthetics.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.P VISION SERVICES (Medicare Advantage Plan)

42CFR 440.120 Att 3.1A-G 12

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Vision Services** permitted under sections 1905(a)(6) and 1905(a)(12) of the Social Security Act. These services include eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.Q DENTAL SERVICES

3.Q.1 Medical and Surgical Services (Medicare Advantage Plan)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes Medical and Surgical Services furnished by a dentist permitted under sections 1905(a)(5)(B), 1905(a)(6) of the Social Security Act. (in accordance with section 1905(a)(5)(B) of the Act) are covered for treatment of medical and surgical dental conditions when furnished by a licensed dentist subject to the limitations of practice imposed by state law.

Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.Q.2 Other Dental Care (Integrated Benefit)

The Enhanced Benchmark Benefit Package includes **Other Dental Care** permitted under sections 1905(a)(5)(B) and 1905(a)(6) of the Social Security Act. These services include professional dental services provided by a licensed dentist or denturist as described in applicable Department rules.

3.R ESSENTIAL PROVIDERS

42CFR 33440.90 — Att 3.1A-G 9

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Clinic Services and Rehabilitative Services** furnished by certain essential providers permitted under sections 1905(a)(9) and 1905(a)(13) of the Social Security Act.

Att 3.1A-PD 9

Services from essential providers are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician and which may include those services provided by community health centers.

3.R.1 Rural Health Clinic Services (Integrated Benefit)

42CFR 440.20 — Att 3.1A-G 2b

Rural Health Clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State plan.

3.R.2 Federally Qualified Health Center Services (Integrated Benefit)

Att 3.1A-G 2c

Federally Qualified Health Center (FQHC) services and other

ambulatory services that are covered under the State plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Att 3.1A-PD 2c

Federally qualified health centers are provided within the scope, amount, and duration of the State's Medical Assistance Program as described under applicable Department rules.

3.R.3 Indian Health Services Facility Services (Integrated Benefit)

42 CFR 431.110(b) AT-78-90

Gen Prov 3.1(g) Gen Prov 3.1(g)

Indian Health Service Facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

3.S MEDICAL TRANSPORTATION SERVICES (Medicaid Providers)

42 CFR 431.53

Gen Prov 3.1 (c)(1)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Medical Transportation Services** permitted under sections 1905(a)(26) and 1905(a)(6) of the Social Security Act.

42CFR 440.170

Att 3.1A-PD 24a

These medical transportation services include transportation services and transportation assistance for eligible persons to get to medical facilities.

Necessary transportation includes transportation for full benefit dual eligible individuals to acquire their Medicare Part D prescription medications.

Payment for meals and lodging may be authorized where appropriate. Ambulance services will be covered in emergency situations or when prior authorized by the Department or its designee.

Att 3.1D C

The Department will assure the provision of necessary transportation of eligible persons to and from providers of Medicaid services.

Limitations. The following service limitations apply to the Medicare/Medicaid Coordinated Benchmark Benefit Package covered under the State plan.

Requests for transportation services will be reviewed and authorized by the Department or its designee. Authorization is required prior to the use of transportation services except when the service is emergency in nature. Payment for transportation services will be made, for the least expensive mode available, which is most appropriate to the recipient's medical needs.

Excluded Services. Transportation to medical facilities for the performance of medical services or procedures which are excluded under the Medicare/Medicaid Coordinated Benchmark Benefit Package are excluded.

3.T LONG-TERM CARE SERVICES

3.T.1 Nursing Facility Services (Medicaid Providers)

Att 3.1A-G 4a

42CFR 440.40

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Nursing Facility Services** permitted under section 1905(a)(4)(A) of the Social Security Act. These services include nursing facility services (other than services in an institution for mental diseases) for individuals determined in

accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

42 CFR 483.10	Gen Prov 3.1 (c)(2)	The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).
		Limitations. The following service limitations apply to Medical Assistance covered under this State plan.
		Once a participant reaches the Medicare Part A first 100 days of post hospitalization limit for skilled nursing facility services, the services will be covered by Medicaid.
	Att 3.1A-PD 4a	Skilled nursing facility services must have prior authorization before payment is made. Such prior authorization is initiated by the eligibility examiner who secures consultation from the regional inspection of care to review for a medical decision as to eligibility for nursing facility services and authorization of payment.
42 CFR 440.140	Att 3.1A-PD 24d	Nursing facility care services must have prior authorization before payment is made.

3.T.2 Personal Care Services (Medicaid Providers)

	Att 3.1A-G 24f	The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Personal Care Services** permitted under section 1905(a)(24) of the Social Security Act. These services include care provided in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
	Att 3.1A-PD 24f	Personal Care Services are provided when ordered by a physician, supervised by a registered nurse, and approved by the Department. R.N. supervision must occur at least every ninety (90) days. Clients whose provider is expected to carryout training programs in the recipient's home for developmentally disabled individuals will also have supervision at least every ninety (90) days by a Qualified Mental Retardation Professional.
	Att 3.1A-PD 26	Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are: • authorized for the individual by a physician in accordance with a plan of treatment; • provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and • furnished in a home.

			The range or list of specific PCS what will be provided is the following: Medical Care and Services. PCS services include medically-oriented tasks related to a participant's physical or functional requirements and provided in the participant's home or personal residence. The provider must deliver at least one (1) of the following services: Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care; Assistance with bladder or bowel requirements that may include helping the participant to and from the bathroom or assisting the participant with bedpan routines; Assisting the participant with physician-ordered medications that are ordinarily self-administered, such as opening the packaging or reminding the participant to take medications; Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; and Non-nasogastric gastrostomy tube feedings if authorized by the Department. Non-Medical Care and Services. PCS services may also include non-medical tasks. In addition to performing at least one (1) of the services listed above, the provider may also perform the following services: Incidental housekeeping services essential to the participant's comfort and health, including changing bed linens, rearranging furniture to enable the participant to move around more easily, laundry, and room cleaning incidental to the participant's treatment; Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment; and Shopping for groceries or other household items specifically required for the health and maintenance of the participant. Type of Service Limitations. The provider is excluded from delivering: Irrigation or suctioning of any body cavities that require sterile procedures or the application of dressings involving prescription medication and aseptic techniques; Insertion or sterile irrigation of catheters; Injecting fluids into the veins, muscles or skin; and administering medication. The list of PCS Providers and their respective qualifications is the following:

			Provider Qualifications for Personal Assistants. All personal assistants must have at least one (1) of the following qualifications: Licensed Professional Nurse (RN) or Licensed Practical Nurse (LPN) and currently licensed by the Idaho State Board of Nursing; or Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. The RMS may require a certified nursing assistant (CNA) if, in their professional judgment, the participant's medical condition warrants a CNA. Provider Training Requirements. When care is provided in the participant's own home, and the participant has a developmental disability, those who provide care must have: Completed one (1) of the Department-approved developmental disabilities training courses; or Experience providing direct services to people with developmental disabilities; The Department determines whether developmental disability training is required. Providers who are qualified as QMRPs are exempted from the Department-approved developmental disabilities training course. Provider Exclusion. If PCS is paid for by Medicaid, a PCS service provider cannot be the spouse of any participant or be the parent of a participant if the participant is a minor child. Care Delivered in Provider's Home for a Child. When care for a child is delivered in the provider's home, the provider must be licensed or certified for the appropriate level of child foster care or day care. The provider must be licensed for care of individuals under age eighteen (18). Care Delivered in Provider's Home for an Adult. When care for an adult is provided in a home owned or leased by the provider, the provider must be certified as a Certified Family Home under IDAPA 16.03.19, "Rules Governing Certified Family Homes." Criminal History Check. All PCS providers, including service coordinators, RN supervisors, QMRP supervisors and personal assistants, must participate in a criminal history check as required by Section 39- 5604, Idaho Code. The criminal history check must be conducted in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." Health Screen. Each Personal Assistance Agency employee who serves as a personal assistant must complete a health questionnaire. Personal Assistance Agencies must retain the health questionnaire in their personnel files. If the personal assistant indicates on the questionnaire that he has a medical problem, he is required to submit a statement from a physician or authorized provider that his medical condition does not prevent him from performing all the duties required of a personal care provider.

			The provider is expected to comply with the terms in the Idaho Medicaid Provider Enrollment Packet Personal Care Services (PCS) specifically sections: Provider Agreement PCS Attendants 2.14-2.19 and RN & QMRP 2.20; and Additional Terms A-3 Training & A-4 Criminal History Clearances. A description of how the State will monitor the quality of PCS services provided is the following: <u>Responsibility for Quality.</u> Personal Assistance Agencies are responsible for assuring that they provide quality services in compliance with applicable IDAPA rules. An Agency on-site review will be completed every two years for PCS participants. Using a quality management approach, Bureau of LTC will participate in improving processes, services, and outcomes. During the first 2 years of implementation 2008 and 2009, the department will only complete outcome surveys for adult PCS participants. The QA/QI system will utilize a system of discovery (the collection of data and direct participant experiences to assess the ongoing implementation of the program); remediation (actions taken to remedy specific problems or concerns that arise); and improvement (the utilization of data and quality information to engage in actions that lead to improvements in the HCBS program). Participant Access (Level of Care Determination) - The design for participant access is meant to assure the following outcomes: Individuals who may need PCS services have access to understandable and user friendly information and processes to receive services and Individuals receive accurate and timely LOC determinations and redeterminations. The processes supporting the achievement of these outcomes are: The use of standardized process and instruments for LOC decisions; Evaluations conducted by qualified staff; LOC decisions are reviewed through a review process and inappropriate decisions are corrected and training is provided when appropriate. (Under development); Annual redeterminations for LOC for all participants; and Processes to get participant experience data from adult participants (Under Development).

			Participant - Centered Service Planning and Delivery - The design for participant centered service planning and delivery is meant to assure the following outcomes: The PCS planning process support the participant's choices; Service Plans (SPs) address the participant's needs and personal goals; SPs are updated and/or revised when warranted by changes in the waiver participant's needs/goals; and Services are delivered in accordance with the SP Plan. The process supporting the achievement of these outcomes is the authorization unit reviews SPs to assure that all needs and goals are addressed. Agency Capacity and Capability (Qualified Providers) - The design for provider capacity and capability is meant to assure the following outcomes: All are subject to an initial review prior to providing services; All Personal Assistance Agencies must complete Department training; All Personal Assistance Agencies are subject to an on-site review every two years; and adult participants have the opportunity to provide feedback to the Department regarding Medicaid PS providers (PES - Under Development). The processes supporting the achievement of these outcomes are: Processes are in place for participants/families/guardians to file complaints or report employee related problems; The Participant Experience Survey (PES) is administered using a statistically valid random sampling process and includes questions regarding employee capabilities and capacity (Under Development); Provider Review Process; and Provider Training Process. Participant Safeguards (Health and Safety) - The design for participant safeguards is meant to assure the following outcomes: SPs address potential and real risks; Assessment/planning and authorization processes are in place that look at participant safeguards and address risks; and Complaints of abuse, neglect and exploitation are investigated (and remediated when substantiated). The process supporting the achievement of these outcomes are policies, procedures, information, materials are in place that allow participants to easily report instances of abuse, neglect and exploitation. Quality management strategies will be evaluated to determine if the information received is: Valid; Measurable; Can be used to remediate individual participant issues; Can be used to evaluate program quality; Can be used for program improvement; and Any needed adjustments in the strategies, tools, reports, etc. will be made as needed.

Limitations. The following service limitations apply to the Medicare/Medicaid Coordinated Benchmark Benefit Package covered under the State plan.

Services are limited to sixteen (16) hours per calendar week, per eligible client.

Att 3.1A-PD
4b(xvii)(g)

3.T.3 Home and Community-Based Services (Medicaid Providers)

Other Home and Community-Based Services are covered for certain participants receiving home and community-based services pursuant to a waiver program authorized under section 1915(c) of the Social Security Act.

3.U HOSPICE CARE (Medicare Advantage Plan)

Att 3.1A-G 18

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Hospice Care** permitted under sections 1905(a)(18) and 1905(o) of the Act. Subject to limitations and restrictions as defined by the individual Medicare Advantage Plan.

3.V DEVELOPMENTAL DISABILITY SERVICES

3.V.1 Intermediate Care Facility Services (ICF/MR) (Medicaid Providers)

42CFR 440.150 Att 3.1A-G 15a

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Intermediate Care Facility Services** permitted under section 1905(a)(15) of the Social Security Act. Services in an intermediate care facility for the mentally retarded (other than such services in an institution for mental diseases) are for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Att 3.1A-PD 15a

Intermediate care services including such services in a public institution for the mentally retarded or persons with related conditions must have prior authorization before payment is made. Such prior authorization is initiated by the eligibility examiner who secures consultation from the periodic medical review team through the nurse consultant for a medical decision as to eligibility for intermediate care services and authorization of payment.

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Att 3.1A-G 15b

Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

3.V.2 Developmental Disability Agency Services (Medicaid Providers)

Att 3.1A-PD 13d
Att 3.1A-PD 13d(1)(a)

The Medicare/Medicaid Coordinated Benchmark Benefit Package includes **Community-Based Services** permitted under section 1905(a)(13) of the Social Security Act. These services include Rehabilitative services which are the core medical rehabilitative services to be provided on a statewide basis by facilities which have entered into a provider agreement with the Department and are that licensed as Developmental Disability Agencies (DDAs) by the Department. Services provided by DDAs are outlined in the applicable Department rules.

Limitations. The following service limitations apply to the Medicare/Medicaid Coordinated Benchmark Benefit Package covered under the State plan.

Att 3.1A-PD 4b(xvii)(d)

Rehabilitative services provided by Developmental Disabilities Agencies are limited to twelve (12) hours reimbursable time allowed for the combination of all evaluations or diagnostic services; the limit of two-hundred (200) treatment sessions per calendar year of speech and hearing therapy; limit of maximum of thirty (30) hours per week of developmental and occupational therapy.

3.V.3 Other Home and Community-Based Services (Medicaid Providers)

Other Home and Community-Based Services are covered for certain participants receiving home and community-based services pursuant to a waiver program authorized under section 1915(c) of the Social Security Act.

3.W MEDICARE ADVANTAGE COST SHARING

The Department pays cost sharing, for which a full benefit dual eligible individual would be liable, for enrollment in a participating Medicare Advantage Plan.

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